

Implementing national mental health carer partnership standards in South Australia

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Abstract.

Objective. The aim of this study was to describe the current state of carer engagement and partnership in two mental health (MH) services in South Australia and the implementation of the six partnership standards in A Practical Guide to Working with Carers of People with a Mental Illness.

Methods. Anonymous surveys of carer experiences and clinician self-ratings of their own practice against the six partnership standards were completed by 94 staff and 58 carers within public and private MH in-patient units before and after exposure of clinicians to education about the partnership standards. Descriptive statistical analysis was performed and, where applicable, a comparative analysis used the two-sample Z-test of proportions. Qualitative data was analysed thematically.

Results. Considerable gaps were evident between carer experiences and clinician self-ratings of their own practice. Overall, the surveys point to the lack of a consistent approach by both public and private services, and suggest potential barriers to fostering carer participation and engagement. Confidentiality was a particularly noted barrier to partnership with carers.

Conclusion. Significant improvement is needed to meet the partnership standards. Brief exposure to the Guide is not, in itself, sufficient to effect change in the overall attitudes, skills and knowledge of clinical staff about engaging carers. Significantly more focus on staff education, clinical discussions and supervision is needed to meet the MH carer partnership standards.

What is known about the topic? Partnership with MH consumers and carers is an established key principle within national MH policies and accreditation standards. Family carers play an important role in supporting consumers' recovery, yet many carers continue to report being excluded, particularly by in-patient clinical staff.

What does this paper add? This is the first study to investigate the partnership standards in practice by comparing the perspectives of carers and in-patient MH clinical staff.

What are the implications for practitioners? Improving partnership with carers of people with mental illness will require significant MH service leadership support shifts in current practice and culture. In addition, a more nuanced understanding of confidentiality is required to overcome the barriers to involving family carers more meaningfully in care.

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Introduction

In any given year, almost 2.5 million people care for a person with mental illness in Australia as a person's parent, spouse, child or other close kin or friend.¹ Carers are key sources of

knowledge and information about the person's symptoms and physical and social needs, they know the person both well and unwell, they are able to identify early signs of relapse and are the primary source of ongoing support. As such, carers have a vital

role in the person's recovery, given that recovery occurs within a social and interpersonal context.² However, carers also have their own needs for support that, if not addressed, can undermine their capacity to care and enable recovery.^{3,4}

Over the past two decades, considerable advances have been made to formally recognise the value, role, rights and needs of carers, along with the importance of partnerships between mental health service providers, consumers and carers. The requirement for mental health services to engage in partnerships with carers is embedded in Australian mental health legislation and policies at national, state and territory levels.^{5,6} However, studies suggest that there remains a significant gap in practice in involving carers effectively in the care process.⁷⁻⁹ A common theme in the research literature is that many family carers feel excluded by healthcare clinicians and facilities from processes of assessment, treatment planning and care, and that partnering with carers in a meaningful way is a major challenge for providers.¹⁰⁻¹³ This is despite the numerous studies highlighting that carers want to work in partnership with providers, integrate their perspective into the care of the consumer and need recognition of their role, validation of the difficulties they face in providing care and access to support services.^{3,10}

There are many reasons for this considerable gap between mental health policy and the experiences of carers in practice, with the skills, knowledge, attitudes and work practices of clinicians frequently cited as barriers to carer participation.^{8,9,14} Research has suggested clinical attitudes and practices are strongly influenced by the biomedical paradigm, within a medicolegal environment, which promotes an individualised focus on the consumer and with concepts of recovery situated in the consumer's personal and unique journey.^{2,15} This can preclude a more holistic focus on the consumer as part of a social system in which the consumer's daily relationships are vital to recovery.^{16,17} Therefore, adopting a partnership approach requires cultural change to shift ingrained practice within mental health services.^{4,9} This is vital given that there also remains a limited understanding of how to apply policy intent in practice.^{7,18}

As a tool to support clinicians to engage and partner with family carers in a meaningful way, and thereby influence change in practice, A Practical Guide for Working with Carers of People with a Mental Illness (hereafter the Guide)¹⁹ was created by a consortium of lived-experience experts in mental health, including Helping Minds, Mind Australia, Private Mental Health Consumer Carer Network (Australia) (PMHCCN), Mental Health Australia and Mental Health Carers Australia. Drawing on previous work undertaken in Australia and internationally, the main aim of the Guide is to provide practical assistance to service providers to work with carers in partnership to enhance outcomes for consumers. The Guide is consistent with Australian mental health policy and legislation, containing workable information related to partnering with carers as described in both the 2010 National Standards for Mental Health Services²⁰ and the 2012 National Safety and Quality Health Service Standards.²¹ This information is captured as six carer partnership standards within the Guide (see [Box 1](#)). The Guide includes a self-assessment tool to enable services to monitor their progress towards meeting the standards, as well as six e-learning modules, each of which explores one of the partnership standards.

In South Australia, two projects using the Guide have been undertaken, one each at a private and public mental health service. The aims of the projects were to: (1) evaluate the services' current understanding and practice against the standards from the perspective of staff and carers; and (2) measure whether, and to what extent, exposure of staff to the standards and associated training modules comprising the Guide improved staff's engagement with carers from the perspective of staff and carers.

Senior clinical staff in each service were included as project team members in order to foster improved buy-in and collaboration by the services to implement the projects into the practice settings, and to promote positive cultural change towards greater partnership with carers following project completion. The projects involved surveying family carers and clinical staff before and after staff exposure to the Guide and the learning modules. Hence, this paper describes the current state of carer engagement in relation to the partnership standards in these two mental health services from the perspectives of carers of people using the services and of clinical staff within the services.

Methods

Ethics approval

The first study was approved by the Flinders University Social and Behavioural Research Ethics Committee; the second was approved by the Departments of Defence and Veterans' Affairs Human Research Ethics Committee and the Southern Adelaide Clinical Human Research Ethics Committee.

Anonymous surveys were developed for clinical staff and carers, who were invited to complete the surveys online in SurveyMonkey or on hardcopy. Participant consent was provided by completion of the online survey or the return of the hardcopy survey via reply paid post to the research team.

Data collection

Carer surveys sought participants' perspectives of interactions between staff of the mental health services and family carers of people who use those services, and the degree to which interactions align with the partnership standards. Demographic data were not collected. Participants were asked to rate their experience as a carer to a series of questions directly related to the partnership standards on a four-point Likert scale with potential responses of 'all of the time', 'most of the time', 'some of the time' and 'never'. The survey questions were developed by the lived-experience members of the research team (JM and SL), one of whom is a mental health consumer and the other a mental health carer. Both are directors with the PMHCCN and presented the draft survey questions to the PMHCCN Board for group discussion and finalisation. This process helped ensure that questions were worded to 'speak' to carers completing the survey and that survey response burden was minimised. Participants were invited to provide further comments in relation to each partnership standard, along with general comments about how the service could improve its engagement with or provide support to carers. Methods to recruit participants included direct distribution of information by the mental health services and through the e-newsletter of the PMHCCN.

Clinicians were invited to identify their occupational group and to rate their current practice in relation to the self-assessment

Box 1. Carer partnership standards as articulated in A Practical Guide for Working with Carers of People with a Mental Illness¹⁹**Partnership Standard 1: carers and the essential role they play are identified at first contact, or as soon as possible thereafter**

- Service identifies care
- Carer views and knowledge sought
- Consumer consent sought for sharing information
- Carers offered updates, information such as medication management, advocacy and carer support

Partnership Standard 2: staff are carer aware and trained in carer engagement strategies

- Carer offered opportunities to participate in all aspects of assessment, care planning, treatment and recovery
- Carer offered crisis information
- Carer offered or receives support from clinicians
- Staff convey hope for person's recovery

Partnership Standard 3: policy and practice protocols regarding confidentiality and sharing of information are in place

- Clinicians provide opportunities to discuss care, treatment, recovery and support plans
- Carer encouraged to share information about the person
- Recovery plan in place

Partnership Standard 4: defined staff positions are allocated for carers in all service settings**Partnership Standard 5: a carer introduction to the service and staff is available, with a relevant range of information across the care settings**

- Carer provided, at first contact, with information about rights, responsibilities, support services, after-hours number
- Early appointment offered to discuss story, concerns, history regarding the person cared for
- Carer provided with a carer information pack
- Carer offered the option of bringing a support person
- Carer is involved in discharge planning
- Carer asked for feedback as part of quality improvement

Partnership Standard 6: a range of carer support services is available

- Carer aware of local carer support and advocacy services
- Carer asked about their own needs and plans

questions anonymously online in SurveyMonkey using a five-point Likert scale with potential responses of 'all of the time', 'most of the time', 'some of the time', 'never' and 'unknown'.

After the preintervention survey data had been collected, clinicians were invited by their clinical management to read the Guide and complete the online educational modules accompanying the Guide. Postintervention surveys were administered 3 months after exposure to this education. The pre- and postintervention surveys contained the same questions and were not matched because they were anonymous. The timeline for the surveys and exposure to the Guide and e-learning modules is shown in Fig. 1.

Data analysis

For the purpose of this paper, to address the first study aim, data analysis focussed on key findings drawn from the preintervention survey data using the frequency and percentage of answers for each scale in each question, together with themes from the comments. Thematic analysis, following the method described by Braun and Clarke,²² was used with the comments. A comparative analysis of staff and carer preintervention survey data for the private service only was undertaken using the two-sample Z-test of proportions. This was conducted using SPSS v23.0 (IBM Corp., Armonk, NY, USA) and its purpose was to test for alignment (or not) between the perceptions of the two

groups of participants regarding the use of the standards in practice. The scale of 'unknown' used in the clinician survey was omitted but did not affect Z-test results because actual numbers were used for the comparisons rather than percentages. There was no comparison for Partnership Standard 4 because data were collected from clinicians only.

To address the second study aim, data analysis focused on changes in carers' perceptions and staff perceptions of their practice in regard to carer engagement and partnership processes within the two mental health services. However, low pre- and postintervention survey response rates within the public facility and a low postintervention survey response rate for the private service limited any statistical analysis of overall changes in perceptions.

Results

Forty-four carers ($n = 36$ and 8 before and after the intervention respectively) participated in the survey for the private mental health service, compared with 14 ($n = 8$ and 6 before and after the intervention respectively) for the public service. Overall, the results were mixed, with responses broadly reflecting a diversity of experiences within the two services. There was minimum discernible change in perceptions across the two time frames.

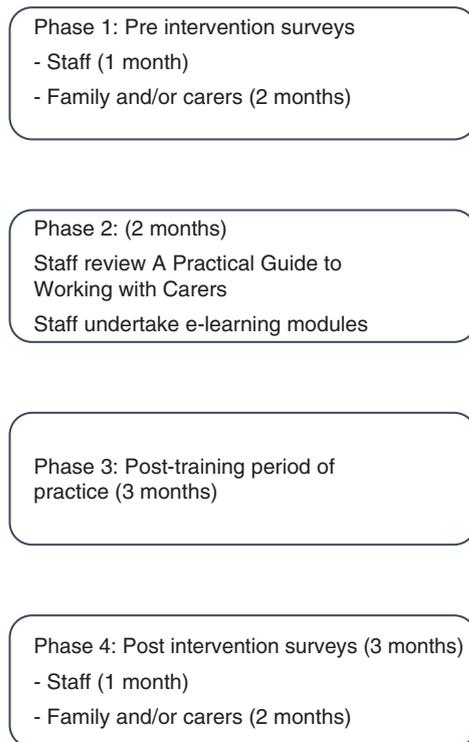


Fig. 1. Project timeline.

For the private service, 40 clinicians completed the preintervention survey and seven completed the postintervention survey. Most were nurses ($n = 34$ and 7 before and after the intervention respectively). For the public service, 32 staff completed the preintervention survey and 15 completed the postintervention survey; over half were nurses ($n = 17$ and 8 before and after the intervention respectively), with others identifying as psychiatrists, allied health and medical registrars. Again, there was minimal discernible change across time frames. The survey results suggest that carers have similar experiences across the two services, with an overall sense of the carer feeling invisible in the recovery process (Table 1).

Survey results for clinicians suggest that far more work is needed for each service to meet the partnership standards. The range of responses to each question, and the large number of participants stating that they did not know ('unknown'), suggests an inconsistency in both the knowledge of carer policies and their application in practice. Three key themes emerged from the comments that reinforce the comments from carers. These were: primacy of consumer consent and autonomy; not the role of nurses; and someone else's role. A significant number of public service participants 'skipped' questions in the surveys; that is, they commenced and submitted the survey but did not select a response to some or all of the questions. Most of the skipped questions were in surveys returned by mental health nurses, with each question skipped by between seven and nine of the 17 nurses completing the surveys. The response rate for individual questions was far better in the private service. Table 2 details the key findings from the clinician preintervention surveys for both services.

The comparison of carer and clinician perceptions of staff performance using results from the private service preintervention survey highlighted several areas that differed significantly ($P < 0.05$) (see Table 3). Table 3 details the key findings for each partnership standard where significant differences were found. Overall, significant differences were found for the ratings of 'never': carers stated that they never had particular experiences, whereas clinicians perceived their own practice in relation to the questions to be far more favourable.

Discussion

Results from the surveys suggest that carers have similar and a broad range of experiences with both mental health service types, but that considerable gaps exist between carer experiences and clinician self-ratings of their own practice. Overall, the survey results point to the lack of a consistent approach by both services and suggest potential barriers to fostering carer participation and engagement.

Invisibility of the carer in the recovery process, manifested through lack of acknowledgement, understanding and inclusion, is pronounced in the results and comments in the carer surveys. This is evident in all partnership standards. Invisibility of the carer has been reported in other studies,^{3,9,16,23} and, in this study, the findings suggest that both services still have a traditional focus on care of the consumer as an individual, separate from their social system of roles and interdependent relationships. If not included in the partnership, the carer is more likely to be excluded from sharing information to support assessment, care planning and treatment, as well as receiving information needed to support the person at home, findings that are also consistent with those of other studies.^{8,17} Studies have reported that such exclusion can result in carers experiencing feelings of powerlessness, anger, frustration and exhaustion,^{8,13,24} which is consistent with some of the comments made in the surveys.

Lack of recognition of carers' own needs is particularly pronounced in the findings in Partnership Standards 5 and 6, which relate specifically to addressing carer rights and need for support. The onus on the carer to seek out information about care and treatment is also pronounced, particularly in the comments, a finding that is consistent with other studies.^{8,13,17} This could be particularly difficult for a carer who is not assertive or is distressed and exhausted. This finding is reinforced by the clinician surveys, which suggest an inconsistent understanding and application of carer policies by clinical staff. Without formal documented processes, or protocols, for engaging with carers, welcoming carers at first contact and providing information about the service, supports, carer rights and responsibilities, a casual approach is likely to continue.

The primacy of consumer consent and autonomy that emerged from the clinician surveys represents both a barrier to fostering carer participation and a particular tension for clinical staff. Although consumer autonomy is an important concept in promoting empowerment in recovery, such an individualistic emphasis means that clinicians may frame their own responsibilities and tasks solely towards the consumer's immediate clinical care needs, and to the exclusion of others.^{16,17} This individualistic focus is reinforced by the legal framework and ethical practice principles by which clinicians are bound, with

Table 1. Key findings from carer preintervention surveys (private and public mental health facilities in South Australia) in relation to carer partnership standards

Participants were asked to rate their experience as a carer to a series of questions directly related to the partnership standards on a four-point Likert scale with potential responses of 'all of the time', 'most of the time', 'some of the time' and 'never'. Total number of carers who responded: Private facility, $N = 36$; Public facility, $N = 8$. GP, general practitioner

Partnership standard	Key findings	Carer comments	Themes
Partnership Standard 1: carers and the essential role they play are identified at first contact, or as soon as possible thereafter	Broad range of experiences of being identified as a carer in both services ranging from never to all the time	<i>My partners tells me the information.</i>	Exclusion from care
	Many carers in both services were never asked for their views or knowledge (41.67% ($n = 15/36$); 25% ($n = 2/8$))	<i>Only recognised as a carer after I inform them and then they ask for consent to convey information. Offered updates... only when I ask.</i>	Invisibility of carer in recovery process
	Carers in both services aware that consumer consent is sought	<i>Never given information unless ask to speak to the doctor and then we find out what is going on with his treatment and medications.</i>	Onus on the carer to seek information
Partnership Standard 2: staff are carer aware and trained in carer engagement strategies	More than half the carers at both services were never offered information about support services, medication strategies or opportunities to enhance their role (61.11% ($n = 22/36$); 62.5% ($n = 5/8$))	<i>Clinical staff appear bemused when I initiate discussion re my husband's care. I am not acknowledged as being a significant person and certainly not as being a valuable contributor towards his care!</i>	Lack of recognition of carer needs
	Half the carers at the private (50%; $n = 18/36$) and one-quarter (25%; $n = 2/8$) at the public service said they had never been offered opportunities to participate in assessment, care planning, treatment and recovery	<i>Quite laughable really! I have never been approached by any clinical staff member for any relevant input, nor have I been offered any supportive information.</i>	Exclusion from care
	Half the carers at both services said they had never been offered crisis information for what to do if the person becomes unwell at home (50% ($n = 18/36$); 50% ($n = 4/8$))	<i>The nurses were friendly enough but never went out of their way to contact me. Our daughter's psychiatrist is willing to communicate with us as long as she is present. Only when I ask.</i>	Lack of recognition of carer needs Onus on carer to seek information Invisibility of carer in recovery process
Partnership Standard 3: policy and practice protocols regarding confidentiality and sharing of information are in place	Broad range of responses from carers in both services regarding the sharing or obtaining of information: one-quarter said they had opportunities to discuss care plans all the time (25.71% ($n = 9/36$); 25% ($n = 2/8$)) and more than one-quarter said that they are never encouraged to share information to support assessment, treatment and support (31.43% ($n = 11/36$); 25% ($n = 2/8$))	<i>Staff are friendly... but my husband's treatment or my own welfare is never discussed.</i>	Exclusion from care
		<i>Only in two instances have I had information about my husband's treatment... nothing has been mentioned re his recovery plan at home once discharged.</i>	
		<i>I do not remember receiving any of this information. I sense that I am not regarded as being a relevant or integral component in my husband's care. My husband came home on a new drug which I wasn't told about.</i>	Invisibility of carer in recovery
Partnership Standard 4: defined staff positions are allocated for carers in all service settings	Carers were not asked questions in relation to this standard		
Partnership Standard 5: carer introduction to the service and staff is available, with a relevant range of information across the care settings	Both services received the least favourable scores for the questions in this partnership standard	<i>I only got the information because I asked for it.</i>	Onus on carer to seek information
	More than half the carers said that they had never been given information about carer rights, support services, after-hours contacts or a carer information pack (58.82% ($n = 20/36$); 75% ($n = 6/8$))	<i>When in doubt I have called the service and the staff have also been very helpful in directing me to the appropriate service/support.'</i>	Lack of recognition of carer needs
	Over 75% ($n = 32/36$; $n = 6/8$) said they had never been asked if they would like to bring a support person, or offered an early appointment to discuss their story and any concerns	<i>I do not remember being given this on his first visit. Nothing given on second visit.</i>	Exclusion from care
	Over half the carers in both services said they had never been asked for feedback about the support they received from the service (75% ($n = 27/36$); 62.5% ($n = 5/8$))	<i>All the information has come from other sources.</i>	Invisibility of carer in recovery

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Table 1. (continued)

Partnership standard	Key findings	Carer comments	Themes
Partnership Standard 6: a range of carer support services is available	Carers from both services indicated that they are aware of some services and support but that this information is more often accessed through sources external to the service With both services, half the carers said they had never been asked about their own needs and plans while supporting the person (52.94% (n = 18/36); 42.86% (n = 3/7))	<i>I'm aware of the support available but not via the hospital. I haven't been advised of the carer support services just yet...my husband is due to be discharged next week so they may go through it in more detail.'</i> <i>My awareness of local support and advocacy is ONLY due to input from a proactive and supportive GP. At no time have any clinical staff approached me to offer any form of supportive input. Staff ask how we are going but do not offer any suggestions about who to see. Could not ask for more care. More involvement should be with the partners as well, we live with the patient 24/7! Perhaps a sit-down chat with someone on admission and then again after discharge. I cannot speak more highly of the service. Overall the service to the patient is very good. I personally don't get any feedback – nothing has been offered to me. I would appreciate if people other than the psychiatrist took time to talk to me as the carer. It would be good if we could be involved with the treatment, and get advice about what to do after the patient leaves the hospital. Feedback on progress while in clinic. I have had none for over 6 weeks. Nice to know if there is a person to contact [for support].</i>	Lack of recognition of carer needs Reliance on external sources for information about carer support Invisibility of carer in recovery
Additional comments from carers			Lack of recognition of carer needs Invisibility of carer in recovery Exclusion from care

confidentiality a core value in developing and maintaining a therapeutic relationship with the consumer. Issues of confidentiality stem from legal precedents that protect the rights of the individual as a distinct legal entity.^{3,25} However, the privileging of the rights of the individual can create tensions for clinicians, particularly where the needs of the consumer and carer may be perceived as competing, with those of family carers positioned as secondary to those of the consumer, who is considered the primary focus of treatment.^{3,9,16}

Although not explicit in the carer surveys, the use of consumer consent and privacy by clinicians is seen by carers to be the key barrier to carer involvement in the assessment and care planning for when the person returns home.^{7,8,17} Confidentiality has been described as an emotive subject for family carers, particularly because it is experienced as diminishing the importance of family carers in the life of the consumer, marginalising them within the mental health service, rendering them powerless and creating difficulties in managing their caring role.^{3,17,26} Although the surveys suggest that clinical staff are confident with obtaining consumer consent all of the time, there is a suggestion of more limited understanding of the nuances and limits of confidentiality, as well as of the rights of the carer to their own confidentiality. This finding is consistent with other studies that have reported that reciprocal rights do not always extend to carers in practice.^{3,8} In effect, these different standards

of confidentiality for clinical staff reflect both the invisibility of carers in treatment planning for recovery and the relegation of the carer role as secondary to that of the consumer within the service.³ Understandably, not respecting carer confidentiality and not keeping confidential information provided by carers separate from consumer clinical records risks compromising relationships that are often already under stress, and may place carers at increased risk. An understanding of the nuances and limits of confidentiality may be improved by regular training, clinical discussions and supervision.^{3,15}

A key theme arising from the comments in the clinician surveys was the lack of understanding by some clinicians that carer engagement is the responsibility of all staff, regardless of discipline. Other studies have found that, in the absence of protocols, staff may assume that others will make contact, with the potential consequence that no one makes contact with the person's family carer.⁴ Conversely, having a dedicated staff member or members as the principal carer contact has been found to significantly increase carer engagement and involvement in care planning as long as new staff are introduced to the procedures.⁴

Nurses have been described as the largest professional mental health care group and have a crucial role in fostering carer participation.²⁷ However, the non-item response in the public service clinical surveys (~50% of nurses 'skipped' each

Table 2. Key findings from clinician preintervention surveys (private and public mental health facilities in South Australia) in relation to carer partnership standards

Clinicians were asked to rate their current practice anonymously online in SurveyMonkey using a five-point Likert scale with potential responses of 'all of the time', 'most of the time', 'some of the time', 'never' and 'unknown'. Total number of clinicians who responded: Private facility, $N = 40$; Public facility, $N = 32$. MO, medical officer; SW, social worker

Partnership standard	Key findings	Clinician comments	Themes
Partnership Standard 1: carers and the essential role they play are identified at first contact, or as soon as possible thereafter	<p>Mixed responses from both services suggesting inconsistent knowledge of policies and procedures</p> <p>Strong focus on obtaining consumer consent, with this happening all or most of the time</p> <p>Half the participants at both services did not know of any documented procedure for welcoming carers (44.74% ($n = 17/38$); 60.87% ($n = 14/23$))</p> <p>Mixed results suggesting inconsistent practice in involving carers at both services in care planning and explaining medication strategies</p> <p>Results suggest that clinicians seek carer views and knowledge most of the time (50% ($n = 19/38$); 62.5% ($n = 15/24$))</p>	<p><i>Carers are welcomed informally, involved with patients' consent.</i></p> <p><i>This would depend on whether patients have given permission.</i></p> <p><i>My own work practice has been to include carers in the care planning process with my clients but ensuring I have their consent.</i></p> <p><i>Some of our consumers do not give consent for us to make contact with their carers in the context of wanting [autonomy].</i></p> <p><i>In a [multidisciplinary] team, it is likely that some staff/disciplines have a greater role with carers.</i></p> <p><i>I am aware of procedures around carer involvement but am not a key part of it.</i></p> <p><i>There are occasions that the patient asks that the carer not be informed of a specific issue.</i></p>	<p>Primacy of consumer consent and autonomy</p> <p>Someone else's role</p>
Partnership Standard 2: staff are carer aware and trained in carer engagement strategies	<p>Approximately one-third of participants in both services said they did not know of a policy for working with carers (28.57% ($n = 10/35$); 38.10% ($n = 8/21$))</p> <p>Both services returned poor results on staff access to carer awareness training and content of any training</p> <p>Many participants did not know whether staff received carer awareness training (35.29% ($n = 12/34$); 61.90% ($n = 13/21$))</p> <p>Results for the practice questions were mixed for both services suggesting inconsistency in carer engagement in practice</p>	<p><i>I am not aware of any carer awareness training available at this time.</i></p> <p><i>Nursing role often involves little direct contact with carers, so don't often get opportunity to engage with them. Contact with carers often made by MOs and SWs.</i></p> <p><i>All of the above relies on consent from the consumer.</i></p> <p><i>The service has an expectation to work with carers (not a written document).</i></p> <p><i>In a [multidisciplinary] team, it is likely that some staff/disciplines have a greater role with carers.</i></p>	<p>Not role of nurses</p> <p>Primacy of consumer consent and autonomy</p>
Partnership Standard 3: policy and practice protocols regarding confidentiality and sharing of information are in place	<p>Consumer consent and agreement over the level of information to share is sought all of the time (80% ($n = 28/35$); 71.43% ($n = 15/21$)); however, the results were mixed concerning revisiting no disclosure, suggesting limited awareness of nuances of confidentiality</p> <p>Results suggest that clinicians in both services have limited awareness of the application of practice guidelines for information sharing with carers and carers' rights to have information kept confidential; the results were far less favourable for the public service, with 80% ($n = 17/21$) stating they did not know whether carer information was kept separately from consumer case notes and nearly half (47.62%; $n = 10/21$) not knowing whether policy and practice guidelines were in place</p>	<p><i>I do not believe it is my role to question a consumer's desire for privacy confidentiality every time we engage...I see this as denying or challenging their right to self-determination and freedom of choice.</i></p> <p><i>The service is constantly supporting carers in the roles but no 'formal' processes are in place that I know of (except to release of confidential information).</i></p>	<p>Primacy of consumer consent and autonomy</p>

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Table 2. (continued)

Partnership standard	Key findings	Clinician comments	Themes
Partnership Standard 4: defined staff positions are allocated for carers in all service settings	<p>Over half the participants in both services said they did not know whether there was a carer champion in the service (55.88% ($n = 19/34$); 66.67% ($n = 14/21$))</p> <p>Mixed results in terms of involving carers being the responsibility of all staff; most participants from both services said they did not know whether there was a network in place to support carer champions (55.88% ($n = 19/34$); 80.95% ($n = 17/21$))</p>	<p><i>Most of our younger consumers do not identify well with the notion of having a carer as they view the idea in a negative way. I have worked with consumers in the spirit of hope and recovery and hence do not emphasise the word 'carer' ...</i></p> <p><i>We have a well-developed Consumer Carer Advisory Committee that has been operational for over 10 years. They are a vital component of our service and provide valuable input.</i></p> <p><i>I would consider the Chair of the Carer and Consumer Advisory Committee a carer champion and Clinical Management the support.</i></p>	<p>Primacy of consumer autonomy</p> <p>Someone else's role</p>
Partnership Standard 5: carer introduction to the service and staff is available, with a relevant range of information across the care settings	<p>The results were the least favourable for this standard for both services, suggesting that inconsistency in staff knowledge about policy and protocols is reflected in practice</p> <p>Responses were mixed in terms of providing carers with information about rights and responsibilities: one-quarter (25%; $n = 5/20$) of participants with the public service did not know, whereas results for the private service were more favourable but still inconsistent</p> <p>Most participants in both services said that they did not know if meet and greet protocols were in place, or if a welcome pack existed.</p>	<p><i>I think some of these services are provided by doctors/social workers...but not from nurses in the in-patient unit.</i></p> <p><i>Nursing staff on floor usually are not the staff who have 'first contact' with a carer.</i></p> <p><i>To the best of my ability I include the carer (with consent of the consumer) in all matters within my scope of practice.</i></p>	<p>Someone else's role</p> <p>Not role of nurses</p> <p>Primacy of consumer consent and autonomy</p>
Partnership Standard 6: a range of carer support services is available	<p>The broad range of responses suggests inconsistency in knowledge and practice; several participants did not know whether carers' needs and plans are regularly reassessed (29.41% ($n = 10/34$); 20% ($n = 4/20$))</p>	<p><i>I offer support to consumers carer (with consent of consumer).</i></p> <p><i>[Name of external service] and [name of other unit in the facility] do this I think.</i></p> <p><i>The Consumer and Carer Advisory committee organise and facilitate carers evenings to support and educate carers twice a year.</i></p>	<p>Primacy of consumer consent and autonomy</p> <p>Someone else's role</p>

question in the preintervention survey), together with the comments (Table 2), suggest that some nurses may not consider that they have a vital role with carers. This is despite nursing as a profession acknowledging itself as the profession best positioned to engage with both carers and consumers.²⁷ However, because basic nursing training may not prepare nurses for working with carers, studies have found that contact by nurses with carers can be informal, ad hoc and unstructured.²⁸ Because carers know the consumer on a day-to-day basis, there is great potential for nurses to learn from carers about how best to provide support when the person is acutely unwell. Other studies have highlighted the importance to, and relief felt by, carers when consulted and included by nurses.²⁷ Given the key role of nurses with carers, several studies have focused on educational programs designed to measure change in nursing clinical practice.^{28,29} Key findings suggest that changes in attitudes and

practice take time and require consistent, ongoing organisational support and leadership to demonstrate a valuing of staff in learning skills in partnering with carers.²⁹ Both services involved in the present study have expressed a commitment to improvement based on the results of the surveys, and the research team has provided the services with several recommendations under each partnership standard, as detailed in Table 4.

Conclusion

Both projects were subject to limitations, particularly with the low preintervention survey response rate for carers with the public service and for the postintervention surveys of clinicians and carers with both services. Despite the limitations, the differences in the perception of carers and staff concerning carer engagement, the lack of discernible change following brief staff

Table 3. Key findings from comparison of clinician and carer perspectives from preintervention surveys in a private mental health facility in South Australia in relation to carer partnership standards

Partnership standard	Key findings
Partnership Standard 1: carers and the essential role they play are identified at first contact, or as soon as possible thereafter	Significant differences ^A with half the clinicians ($n = 19$) thinking that carers views and knowledge are sought most of the time but only one-fifth of carers ($n = 7$) thinking this was the case ($P = 0.005$); almost half the carers ($n = 15$) thought this never happens, but no clinicians thought this never happens ($P < 0.001$) 61% ($n = 22$) of carers said they were never given explanations for medication management but only 7.89% ($n = 3$) of clinicians thought this never happens ($P < 0.001$) Half the carers ($n = 19$) said they were never given access to advice concerning advocacy, rights and support, but no staff thought this never happens ($P < 0.001$), with half the staff ($n = 19$) thinking this happens all the time
Partnership Standard 2: staff are carer aware and trained in carer engagement strategies.	No clinicians said that carers were never offered opportunities to participate in all aspects of assessment and care planning, whereas half the carers ($n = 18$) said that this was their experience ($P < 0.001$) Only one clinician said that carers were never provided with information regarding services and strategies if a crisis occurs, with 40% ($n = 14$) of clinicians stating that this happens all the time; conversely, 50% ($n = 18$) of carers said that they were never provided with this information, with only 13.89% ($n = 5$) saying this happens all the time
Partnership Standard 3: policy and practice protocols regarding confidentiality and sharing of information are in place	Almost half the clinicians ($n = 16$) thought that carers were provided with opportunities to discuss care most of the time, whereas only 11.43% ($n = 4$) of carers said this was the case ($P = 0.001$); one-quarter of carers ($n = 9$) said that this never happens, compared with 5.71% ($n = 2$) of clinicians ($P = 0.021$) 31.43% ($n = 11$) of carers said they were never encouraged to share information to support assessment and treatment, whereas no clinicians thought this was the case ($P < 0.001$)
Partnership Standard 5: carer introduction to the service and staff is available, with a relevant range of information across the care settings	Significant differences ^A were found across all questions in ratings of whether the action never occurred, with a far greater proportion of carers stating that these never occurred; 57.93% ($n = 21$) of carers said that they were never provided with information, with only two clinicians saying this was the case ($P < 0.001$) Over half the carers ($n = 20$) said that they had never been provided with a carer information pack compared with only 14.29% ($n = 5$) of staff thinking this was the case ($P < 0.001$) No clinicians thought that carers were never involved in discharge planning, whereas 41.67% ($n = 15$) of carers said this was their experience ($P < 0.001$) Three-quarters of carers ($n = 27$) said that they had never been asked for feedback on the service, whereas only 8.82% ($n = 3$) clinicians thought that this was the case ($P < 0.001$)
Partnership Standard 6: a range of carer support services is available	Significant differences ^A were found with the ratings of 'never': over one-third ($n = 12$) of carers said they were never provided with information about local carer support services, whereas only one clinician thought this was the case ($P < 0.001$) Over half ($n = 18$) the carers said they were never asked about their own needs and plans, but only two clinicians thought this never happens ($P < 0.001$)

^A $P < 0.05$.

exposure to the education in the Guide, the survey comments and the consistency of findings with those of other studies suggest that significantly more improvement is needed to meet the partnership standards. Brief exposure to education through the Guide alone may not be sufficient to effect change in the overall attitudes, skills and knowledge of clinical staff about carers. Key recommendations focus on: (1) developing and implementing procedures and protocols, with responsibilities assigned for updating and orienting new staff to these; (2) orienting all staff to the key carer policies and legislation; (3) facilitating ongoing team discussions regarding areas of tension, such as consent and confidentiality; (4) having dedicated staff members as principle carer contacts; and (5) requiring staff to complete the e-learning modules with the Guide as part of mandated clinical training modules. It is recommended that future research should use different and more rigorous methods. These could include ethnographic methods to better understand how the standards are operationalised in day-to-day practice by individuals and teams, longitudinal research given that some consumers and carers may only have intermittent contact with the services and/or methods aimed at matching pre- and postintervention surveys to enable

more direct comparison of potential changes in perspectives over time. The present study arose from a participatory approach in which mental health consumer and carer members of the PMHCCN devised the Guide and then a small number of senior clinical management staff were involved in formulating the plan for recruitment and roll-out of the project steps to match the research settings. However, future research could include a participatory approach inclusive of all stakeholders in collaboration across all research stages to facilitate engagement and partnership between clinicians and carers.

Competing interests

The authors declare that they have no competing interests.

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Table 4. Recommendations to improve clinical practice against each mental health carer partnership standard
FOI, freedom of information

Partnership standard	Recommendations
Partnership Standard 1: carers and the essential role they play are identified at first contact, or as soon as possible thereafter	<p>Develop and document a procedure for welcoming carers. Communicate this procedure across the teams to ensure that all staff are aware. Identify which staff position has responsibility for updating the document and for monitoring consistency in implementation</p> <p>Ensure that carers are routinely identified during assessment and that this is recorded. Consider implementing the use of a carer nomination form for each new consumer at intake</p> <p>Ensure that carers are routinely involved in all aspects of assessment, care and discharge planning where consent permits. Ensure all involvement is documented</p> <p>Ensure all staff, regardless of discipline, are familiar with the policy guidelines around consent and confidentiality. This should occur at orientation with retraining at regular intervals</p>
Partnership Standard 2: staff are carer aware and trained in carer engagement strategies	<p>Provide all staff on a regular basis with access to training that covers the policy and legislative requirements that they are expected to demonstrate in their practice. This should help staff better understand the importance placed on partnering with carers.</p> <p>Include the e-learning modules in the Guide^A as part of orientation for new staff</p> <p>Invite carers to deliver face-to-face training/education on their lived experience as part of staff development</p> <p>To enable improved understanding of the importance of the carer, provide training/education to all staff on the role of social support in veteran recovery</p> <p>Enable regular staff discussion, in both team meetings and individual clinical supervision, concerning tensions in clinical practice that involve inclusion of carers</p>
Partnership Standard 3: policy and practice protocols regarding confidentiality and sharing of information are in place	<p>Provide regular staff training on consent and confidentiality legislation and protocols. Ensure that all staff are familiar with the <i>Commonwealth Privacy Act</i> and the <i>SA Mental Health Act 2009</i>, which define what information can be conveyed to families and other carers and under what circumstances. Include discussion of the differences between general and sensitive information. Staff education should include carer rights to confidentiality</p> <p>Facilitate regular discussions with staff concerning obtaining and revisiting consent. Encourage discussion of difficulties or tensions that staff experience and how these can best be managed</p> <p>Develop a written protocol for revisiting consent</p> <p>Develop and implement a protocol to ensure confidential information provided by carers is kept separately from any information that the consumer can access under FOI. Ensure that this is communicated to all staff</p>
Partnership Standard 4: defined staff positions are allocated for carers in all service settings	<p>Designate a staff member as principle carer contact with reporting on carer issues as a standard agenda item for all staff and management meetings</p> <p>Investigate the possibility of obtaining a carer consultant position</p>
Partnership Standard 5: a carer introduction to the service and staff is available, with a relevant range of information across the care settings	<p>Develop a welcome pack to be provided to new carers at first meeting. This should contain information about the service, support services and carer rights and responsibilities. This could be developed with involvement from the carer representatives</p> <p>Designate a staff position with responsibility for updating the welcome pack</p> <p>Develop and implement a protocol for providing the welcome pack to new carers</p> <p>Maintain a display of carer information at reception as an additional resource</p>
Partnership Standard 6: a range of carer support services is available	<p>Ensure that carer issues are an embedded agenda item for consumer and carer advisory group meetings to encourage representatives to raise issues from carers</p> <p>Ensure that there is equal representation of carers and consumers on the advisory group</p> <p>Regularly obtain carer feedback on the service as part of quality improvement activities. This could be done in the same way that consumer feedback is obtained</p> <p>Invite representatives from carer support organisations to talk at both staff and advisory group meetings about services offered</p>

^AA Practical Guide for Working with Carers of People with a Mental Illness.¹⁹

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